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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

EVERETT HOGGE and PRISCILLA HOGGE,

Plaintiffs,

vs.

A.W. CHESTERTON COMPANY, *et al*,

Defendants.

Case No.: C 07 2873 EDL

DECLARATION OF DEBORAH R. ROSENTHAL IN SUPPORT OF PLAINTIFFS' MOTION FOR ORDER SHORTENING TIME FOR BRIEFING AND HEARING OF PLAINTIFFS' MOTION FOR REMAND

[28 USC § 1447; F.R.C.P. 7(b); ND CA Local Rule 6-3]

Current Hearing Date: July 10, 2007
Proposed Hearing Date: June 19, 2007
Time: 9:00 a.m.
Courtroom: E, 15th Floor
Magistrate Judge: Hon. Elizabeth D. Laporte

I, Deborah R. Rosenthal, declare as follows:

1. I am an attorney admitted to practice law before this Court and all the courts of the State of California and am an associate of Paul, Hanley & Harley, LLP, attorneys of record for plaintiff herein. The matters stated herein are true to my own personal knowledge, except as otherwise stated. If called upon as a witness to, I could and would testify to the following facts.

2. Attached hereto as **Exhibit "A"** is a true and correct copy of the January 2, 2007, Declaration of David H. Harpole, Jr., M.D., in Support of Trial Preference, filed in *Everett Hogge and Priscilla Hogge*, S.F.S.C. Case No. 452846.

3. Attached hereto as **Exhibit "B"** is a true and correct copy of the San Francisco County Superior Court's Order Granting Plaintiff's Third Motion for Preference, filed in *Everett Hogge and Priscilla Hogge*, S.F.S.C. Case No. 452846, on January 11, 2007.

4. On Friday June 1, 2007, I asked counsel for JOHN CRANE INC. to stipulate to hearing Plaintiffs' Motion for Remand on shortened time. On Monday, June 4, 2007, defense counsel informed me that he was agreeable to accelerating the hearing date by one or two weeks but would not agree to shortening the time within which defendant could prepare and file and serve its opposition. Attached hereto as **Exhibit "C"** is a true and correct copy of the exchange of email correspondence memorializing the parties' meet and confer efforts regarding accelerating the briefing and hearing schedule for Plaintiffs' Motion for Remand.

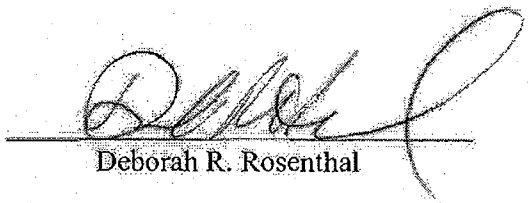
5. Plaintiffs are willing to waive their reply if the Court prefers in order to hear the motion on shortened time.

6. The issues in Plaintiffs' Motion for Remand are: whether JOHN CRANE INC's Notice of Removal sets forth sufficient allegations to establish federal court jurisdiction and removability; i.e., (1) whether California citizen defendants Plant Insulation Company, Hill Brothers Chemical Company, Quintec Industries, and Sepco Corporation remain in the action, which was initially filed in California; (2) whether JOHN CRANE INC. obtained unanimous consent to removal of all defendants that remain in the action); and (3) whether the case became removable within the past 30 days.

7. There have been no previous time modifications in the case, other than the state court's grant of plaintiff's motion for trial preference in the San Francisco Superior Court proceedings.

///

I declare under the penalty of perjury under the laws of the State of California and of the United States that the foregoing is true and correct. Executed on June 4, 2007, in Berkeley, California.



Deborah R. Rosenthal

EXHIBIT "A"

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Attorneys for Plaintiffs

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN FRANCISCO-COURT OF UNLIMITED JURISDICTION

EVERETT HOGGE and PRISCILLA HOGGE, Plaintiffs, vs. A. W. CHESTERTON COMPANY, et al., Defendants.	Case No.: 452846 **DECLARATION OF DAVID H. HARPOLE, Jr., M.D., IN SUPPORT OF TRIAL PREFERENCE** [C.C.P. § 36 (d)] Date: January 10, 2006 Time: 3:00 p.m. Dept: 611, Hon. Diane E. Wick Complaint Filed: June 2, 2006 Trial Date: None Set

I, David H. Harpole, Jr., M.D. declare as follows:

1. I am a physician involved in the care and treatment of EVERETT HOGGE, one of the plaintiffs in this lawsuit. I examined Mr. HOGGE most recently on or about 12/19/06, and continue to monitor his health regularly as his treating physician.

2. Mr. HOGGE initially presented in February of 2006 with increasing shortness of breath and a cough. Review of radiological studies performed at that time revealed a large left-sided pleural effusion, necessitating a thoracentesis. In an attempt to ascribe a clear etiology to his complaint, Mr. HOGGE underwent a diagnostic thoracoscopy with multiple pleural biopsies, a second thoracentesis and a talc pleurodesis on March 29, 2006. Review of pathology materials

from said procedure resulted in a diagnosis of malignant mesothelioma, a terminal disease. Attached hereto as Exhibit A, page 1, is a true and correct copy of the surgical pathology report showing the mesothelioma diagnosis from pathology obtained on March 29, 2006.

3. It is my medical opinion, as a physician involved in the care and treatment of EVERETT HOGGE, that there is substantial medical doubt Mr. HOGGE will survive beyond three months from the date of this declaration. My medical opinion is based on all of the facts and factors as specifically outlined below.

4. My opinion is based upon several factors: my training as a physician; my considerable experience treating cancer patients; my experience treating patients suffering from Mr. HOGGE's specific disease of mesothelioma; my specialized knowledge regarding the typical course of this cancer in patients like Mr. HOGGE; my knowledge of the specifics of Mr. HOGGE's current condition; how his condition has deteriorated since his diagnosis and the significance of his signs and symptoms; and my knowledge of the specifics of the recent treatments rendered to Mr. HOGGE and how such treatments affect his prognosis.

5. My Curriculum Vitae is attached hereto as Exhibit B. As delineated in my curriculum vitae, I currently serve as the Vice Chair of Faculty Affairs and Education in Duke University School of Medicine's Division of Cardiovascular and Thoracic Surgery. I am a board certified in thoracic surgery. I was trained in thoracic oncology at the Harvard Medical School from 1993 to 1995. My clinical and research interests include but are not limited to thoracic oncology, general thoracic surgery, benign and malignant disease of the lung, esophagus, and mediastinum; advanced airway and thoracoscopicsurgery, hyperhidrosis palmaris, and mesothelioma.

6. I have considerable experience treating patients suffering from mesothelioma, the specific form of cancer Mr. HOGGE was diagnosed with on March 29, 2006. I have treated dozens of such patients and am very familiar with the typical course of the disease. Duke is a cancer treatment center and in addition to my own experience I have observed the treatment of numerous other patients with mesothelioma. As delineated in my curriculum vitae, my experience with malignant mesothelioma extends to having co-authored several abstracts

regarding the cancer, including *Patterns of failure following planned tri-modality therapy for malignant mesothelioma* (Proc. Society of Surgical Oncology 48: 25, 1995), and *Multimodality treatment of malignant pleural mesothelioma, results in 94 consecutive patients* (Proc. American Society of Clinical Oncology, 1995). This experience has contributed greatly to my understanding of this disease, its treatment options, and its inevitably terminal course. The articles specifically addressed treatment options and survivability in mesothelioma patients.

7. Mr. HOGGE has been diagnosed with malignant mesothelioma, a terminal disease, and his health is in decline. The lengthy and extensive surgery to remove his left lung and sections of his pleura and ribcage at Duke University Medical Center on May 24, 2006 did not cure him of his disease. Attached hereto as Exhibit A, page 2-3, is a true and correct copy of Mr. HOGGE's operative report from that day.

8. Mr. HOGGE had to undergo re-exploration surgery on May 25, 2006, as he had bleeding. As indicated on the operative report, Mr. HOGGE's thoracotomy incision was re-opened and examined. Mr. HOGGE's chest was irrigated and his bleeding was controlled with Bovie electrocautery. Attached hereto as Exhibit A, page 4-5, is a true and correct copy of Mr. HOGGE's operative report from that day.

9. Mr. HOGGE was finally discharged on postoperative day 6 after his left extrapleural pneumonectomy. Attached hereto as Exhibit A, page 6-7, is a true and correct copy of Mr. HOGGE's discharge summary of May 30, 2006.

10. Following discharge, Mr. HOGGE had difficulty controlling his diabetes and blood sugars. He lost significant weight following his surgery – 5 kg (11 pounds) in less than three weeks. Attached hereto as Exhibit A, page 8-9, is a true and correct copy of Mr. HOGGE's thoracic surgery clinic note of June 13, 2006.

11. I referred Mr. HOGGE to Dr. Marks, who recommended radiation to the tumor bed to reduce the risk of local/regional recurrence. There are side effects of radiation, including injury to the kidney, stomach, esophagus, heart, lung, which can be minimized, but cannot be avoided completely. Radiation is performed to reduce the risk of recurrence, but cannot stop it.

Radiation was not recommended for a few weeks after the initial consultation, to allow Mr. HOGGE to try to regain some more of his strength following his left extrapleural pneumonectomy. Dr. Marks also discussed chemotherapy with Mr. HOGGE during his initial consultation, following radiation, given the patterns of failure for mesothelioma. It is also worth noting that as of July 25, 2006, Mr. HOGGE's weight was down to 135.7 pounds. Attached hereto as Exhibit A, page 10-12, is a true and correct copy of Mr. HOGGE's consultation report with Dr. Marks of July 25, 2006.

12. I also referred Mr. HOGGE to Dr. Crawford, who evaluated him on August 24, 2006. Dr. Crawford noted that Mr. HOGGE had lost 15 pounds since his left extrapleural pneumonectomy with difficulty eating, and that he was having difficulty controlling his diabetes since his surgery. Dr. Crawford had an extensive discussion with Mr. HOGGE regarding the likely course of his disease, and that fully resectable mesothelioma is uncommon. Radiation, plus chemotherapy ***may*** have some benefit in ***decreasing recurrence and/or delaying time to relapse.*** Attached hereto as Exhibit A, page 13-16, is a true and correct copy of Dr. Crawford's report of August 24, 2006.

13. As noted in September 5, 2006 radiation oncology clinic note, Mr. HOGGE was evaluated with a CT to plan his radiation treatment. It was noted at that time that it would not be possible to deliver the desired dose to the inferior aspect of the tumor, without exceeding the cardiac and bowel tolerances, which was further complicated by the fact that the tumor wrapped around the pericardial surface both anteriorly and posteriorly. Radiation oncology clinic notes of September 5, 2006 is attached hereto as Exhibit A, page 17-18.

14. Mr. HOGGE's mesothelioma tumor has grown over the pericardial surface. The pericardium is the lining of the heart. Thus, Mr. HOGGE's tumor is growing around his heart. This particular tumor was removed during the initial surgery, but has since recurred. Malignant tumors growing next to the surface of the heart are life threatening! As the tumor grows it could stop Mr. HOGGE's heart causing death immediately. There is no treatment available to lessen this threat.

15. Mr. HOGGE's weight loss is a result of his tumor's growth. As cancerous tumors grow they demand more and more energy, thus depriving the rest of the body. Because Mr. HOGGE is unable to consume sufficient calories to meet his tumor's demands his body is converting fat and muscle to energy to feed his tumor. This further weakens his body defenses to even simple colds or flu. Any infection or serious illness is life threatening to Mr. HOGGE because of his overall state of poor health.

16. The removal of one lung (which decreases Mr. HOGGE's ability to breathe), radiation and chemotherapy all combine to weaken Mr. HOGGE and make him susceptible to disease and or infection.

17. Mr. HOGGE's mesothelioma is likely to kill him. However, his overall poor health and weakened defenses also make him vulnerable to flu, pneumonia and other common illnesses, any of which could hasten his death.

18. As outlined in detail above, because of the complexity and the high risks involved with his left extrapleural pneumonectomy, he is now more susceptible to other diseases, which will significantly impact his health. The variety of chemotherapy and radiation treatments Mr. HOGGE has or will undergo are solely palliative in nature and not intended to cure him of his cancer, as ***a cure is not currently possible with Mr. HOGGE's malignant mesothelioma.*** Rather, such treatments are or will be administered with the intent of ***slowing*** the progress of his disease. The benefits of such treatments are variable in terms of the amount of additional time they can add to a patient's lifespan. Mr. HOGGE's symptoms of severe shortness of breath, coughing, fatigue and nausea are all very standard for those diagnosed with malignant mesothelioma. His loss of over 20 pounds since the onset of his disease, from 155 to 135 pounds, and his constant fatigue and weakness are attributable to the voracious energy demands of his growing tumors. Review of radiological studies performed on December 19, 2006 by a Dr. Crowder at Duke University Medical Center revealed a new pericardial effusion. These symptoms are clear indicators that the disease is still present, is progressing, and that Mr. HOGGE's condition is continuing to deteriorate. His anorexia complicates his struggles to

regulate his insulin-dependent diabetes. All of these factors contribute to my opinion regarding the doubt of his survival beyond three months.

19. I have treated innumerable cancer patients and dozens of mesothelioma patients. I recognize when cancer patients are beginning their final decline and are unlikely to recover. There is no set formula and "decision matrix" for estimating life expectancy in terminal patients. Rather, such judgments are made on a case by case basis based on the physician's training, education, and experience. I have attempted to present, in so far as possible, the basis for my conclusions and opinions regarding Mr. HOGGE.

20. Attached hereto as Exhibit C are true and correct copies of Mr. HOGGE's most recent medical records, dating September 11, 2006 and November 14, 2006.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on January 2, 2007 in Durham, North Carolina.

David H. Harpole, Jr., M.D.

EXHIBIT A

Patient: HOGGE,CLAIBORNE FB8179

AP Surgical Pathology: Final 05/16/2006 Acc# 00SO06014911 MADDEN,JOHN F.

Surg Path

CLINICAL HISTORY:
Not provided.

GROSS EXAMINATION:
Outside slide number 1: "HR:S2275-06"
Date of surgery: 3-29-06
Number of slides: 17 (15 unstained)

Outside slide number 2: "HR:NG152-06"
Date of surgery: 3-29-06
Number of slides: 2

Received from: Henrico Doctor's Hospital
Department of Pathology
1602 Skipwith Road
Richmond, VA 23229
Tel: 804289-4500

Accompanying letter addressed to Dr. Harpole
Outside path report received? Yes
Material to be returned? Yes

MICROSCOPIC EXAMINATION:
Microscopic examination is performed.

DIAGNOSIS:
1. "LEFT PLEURAL" (BIOPSY) OUTSIDE SLIDE REVIEW, HR:S2275-06, HENRICO DOCTOR'S HOSPITAL, RICHMOND, VA, PROCEDURE DATE 3-29-06:

MALIGNANT MESOTHELIOMA.

NOTE: Outside report indicates tumor cells were calretinin (+), cytokeratin 5/6 (+), MOC-31 (-), B72.3 (-).

2. "PLEURAL FLUID" (CYTOLOGIC PREPARATION), OUTSIDE SLIDE REVIEW, HR:NG-152-06, SAME AS ABOVE, PROCEDURE DATE 3-29-06:

MALIGNANT TUMOR CELLS, CONSISTENT WITH MALIGNANT MESOTHELIOMA.

I certify that I personally conducted the diagnostic evaluation of the above specimen(s) and have rendered the above diagnosis(es).

John F. Madden, MD, PhD Pager# 9702912

Electronically signed: 05/21/06
Performed by: SURGICAL PATHOLOGY BOX 3712 DUMC DURHAM, NC 27710

Patient: HOGGE, CLAIBORNE FB8179

ProcOP OP Report: Final 05/24/2006 00:00

Operative Report

MRN: FB8179

HOGGE, CLAIBORNE
Date of Procedure: 05/24/2006

DOB: 06/24/1941 Age: 64
Operative Report
Attending: David Harold Harpole, MD
Dictating: Jeffrey Giles Gaca, MD

PREOPERATIVE DIAGNOSIS:
Left malignant mesothelioma.

POSTOPERATIVE DIAGNOSIS:
Left malignant mesothelioma.

PROCEDURES:
Left extrapleural pneumonectomy.

SURGEON:
David H. Harpole, Jr., M.D.

ASSISTANT:
Jeffrey Giles Gaca, M.D.

TEACHING ASSISTANT:
Shari Meyerson, M.D.

ANESTHESIA:
General anesthesia.

ESTIMATED BLOOD LOSS:
600 mL.

FLUIDS:
500 mL of lactated Ringer's, 500 Hextend.

SPECIMENS:
Left lung and pleura.

DRAINS:
Left pneumonectomy chest tube.

CONDITION:
Stable.

DESCRIPTION OF PROCEDURE:
The patient was taken to the operating room and placed supine on the operating table. After adequate general endotracheal anesthesia was obtained, the patient was placed in the right lateral decubitus position, where the left chest was prepped and draped in the usual sterile fashion.

The patient had two small prior incisions from a thoracoscopic pleural biopsy; these were both resected and ellipsed down to the chest wall, then closed with Vicryl sutures and staples in the skin.

A posterolateral thoracotomy extended anteriorly was then made over the sixth interspace and using Bovie electrocautery, the latissimus dorsi and serratus muscles were then divided. The sixth rib was then mobilized subperiosteally and removed in toto. The extrapleural dissection was then begun bluntly. We were able to completely mobilize the lung and pleura superiorly, inferiorly, and anteriorly to the level of the pericardium. The diaphragm was then divided anteriorly and using blunt dissection, the diaphragm was mobilized off the peritoneum in toto. At this point, posteriorly we were able to similarly mobilize the pleura off of the aorta and the aortic arch. When the pleura was completely mobilized and the diaphragm mobilized off of the peritoneum, we then opened-up the pericardium anteriorly. At this point, the right PA artery was then identified and divided with the EndoGIA white load stapler. We then divided the superior pulmonary vein with the EndoGIA white load stapler and the inferior pulmonary vein was then divided with the EndoGIA white load stapler. We identified the main stem bronchus and the right main stem bronchus was then divided with the TA30 stapler. At this point, the remainder of the diaphragm anteriorly was then divided and the lung pleura and pericardium were then passed off the field as specimens. The area was then copiously irrigated.

The lymph nodes at level 7 and level 4 were then removed. The areas were checked for bleeding, then a Prolene mesh patch was then brought-up into the field, and was sewn to the remnant of the diaphragm in a circumferential fashion using interrupted 0 Prolene sutures.

At the completion of the patch, all areas were inspected for bleeding; there was none. A separate stab incision was made for a 28-French chest tube, which was affixed to the skin with nylon suture. The chest wall was then closed with figure-of-eight #1 Vicryl sutures to approximate the ribs. The serratus muscles were then reapproximated using a 0 Vicryl suture. A #2 Vicryl suture was then used to approximate the latissimus muscle. A 2-0 Vicryl was then placed in the subcutaneous tissues and staples in the skin. Sterile dressings were then applied.

Dr. Harpole was present for the critical portions of the case.

JEFFREY GILES GACA, MD

David H. Harpole, MD
Division of Cardiovascular and Thoracic Surgery
ELECTRONICALLY SIGNED ON
June 01, 2006 AT 7:37:49 AM

DD: 05/25/2006
DT: 05/25/2006
MEDQ/JOB: 229042/221242175

Patient: HOGGE, CLAIBORNE FB8179

ProcOP OP Report: Final 05/25/2006 00:00

Operative Report

MRN: FB8179

HOGGE, CLAIBORNE
Date of Procedure: 05/25/2006

DOB: 06/24/1941 Age: 64
Operative Report
Attending: David Harold Harpole, MD
Dictating: Jeffrey Giles Gaca, MD

PREOPERATIVE DIAGNOSIS:
Hemorrhage, status post extrapleural pneumonectomy.

POSTOPERATIVE DIAGNOSIS:

OPERATION:
Re-exploration for bleeding.

SURGEON:
David H. Harpole, Jr., M.D.

ASSISTANT:
Jeffrey Giles Gaca, M.D.

TEACHING ASSISTANT:
Shayi L. Meyerson, M.D.

FINDINGS:
Small chest wall bleeder.

COMPLICATIONS:
None.

DESCRIPTION OF PROCEDURE:
The patient was taken to the operating room, and placed supine on the operating room table. After adequate general endotracheal anesthesia was obtained, the patient was placed in the right lateral decubitus position. The chest was prepped and draped in the usual sterile fashion. The thoracotomy incision was then re-opened, the staples were removed, the sutures were cut, and the chest was then re-examined. It was packed. There was a large amount of clot within the chest. It was irrigated with three liters of warm saline. We then identified a small chest wall bleeder, which was controlled with Bovie electrocautery. Antibiotic irrigation was then used. There were no more areas of bleeding and we tried to reclose the chest using interrupted #1 Prolene sutures, figure-of-eight around the ribs and the serratus muscle was then reapproximated with #1 Vicryl suture, and the latissimus muscle was reapproximated with 2-0 Vicryl suture and subcutaneous tissues approximated with 2-0 Vicryl suture.
Staples were then placed in the skin. A sterile dressing was applied. Dr. Harpole was present for the critical portions of the case.

JEFFREY GILES GACA, MD

David H. Harpole, MD
Division of Cardiovascular and Thoracic Surgery
ELECTRONICALLY SIGNED ON
June 01, 2006 AT 7:37:50 AM

DD: 05/25/2006
DT: 05/25/2006
MEDQ/JOB: 574987/221242850

Patient HOGGE, CLAIBORNE FB8179

Dictated Rpt: Final 05/30/2006 00:00

Discharge Summary

MRN: FB8179

HOGGE, CLAIBORNE
Admitted: 05/24/2006
Discharge: 05/30/2006
DOB: 06/24/1941 Age: 64
Discharge Summary
Attending: David Harold Harpole, MD
Dictating: Stafford Scott Balderson, PA

HISTORY OF PRESENT ILLNESS:
Mr. Hogge is a 64-year-old gentleman who was recently diagnosed with malignant mesothelioma. He presents at this time for extrapleural pneumonectomy.

PAST MEDICAL HISTORY:
Pulmonary includes mesothelioma, hypertension, and type 1 diabetes mellitus.

MEDICATIONS:
1. Insulin, Humulin 18 N and 5 regular q.a.m., 13 N and 5 regular q.p.m. 2. Lipitor 20 mg p.o. daily. 3. Protonix 40 mg p.o. daily. 4. Vitamin E 400 international units daily. 5. Centrum Silver. 6. Toprol XL 25 mg p.o. daily.

DRUG ALLERGIES:
Percocet.

PHYSICAL EXAMINATION:
Vital signs: The patient is afebrile. Weight is 68.9 kg. Blood pressure is 182/82. Heart rate is 100. Neck: Supple. Lymph nodes: There is no supraclavicular or cervical adenopathy noted. Chest: Bilateral breath sounds are clear to auscultation. Heart: S1 greater than S2. No murmurs, rubs, or gallops. Abdomen: Positive bowel sounds in all 4 quadrants. Nontender, nontender, and soft. Extremities: No clubbing, cyanosis, or edema. Neurologic: Cranial nerves II through XII grossly intact.

HOSPITAL COURSE:
The patient underwent a left extrapleural pneumonectomy by Dr. David Harpole on 5/24/06. Immediately postoperatively, the patient was noted to have high chest tube output. As such, on postoperative day 1 he was taken back to the OR for re-exploration for bleeding. The patient tolerated this procedure well. He had no further difficulty noted. His chest was subsequently removed on postoperative day 2. He was started on a clear liquid diet on postoperative day 3. He continued to improve. His diet was liberalized, and he was subsequently deemed suitable for discharge on postoperative day 6. The patient is to follow up with Dr. Harpole in clinic on 6/13/06 at 1:15 p.m.

DISCHARGE MEDICATIONS:
1. Zydone one tablet p.o. q.4 h. p.r.n. pain. 2. Colace 100 mg p.o. b.i.d. while taking the Zydone. 3. Insulin, Humulin 12 units regular at breakfast, 12 units regular at lunch, 10 units regular at dinner, 12 units NPH at bedtime.

PRINCIPAL DIAGNOSIS:
Mesothelioma.

STAFFORD SCOTT BALDERSON, PA-C
Division of Cardiovascular and Thoracic Surgery

David H. Harpole, MD
Division of Cardiovascular and Thoracic Surgery
ELECTRONICALLY SIGNED ON
June 01, 2006 AT 7:37:55 AM

DD: 05/31/2006
DT: 05/31/2006
MRDQ/JOB: 230927/222762587

Patient: HOGGE, CLAIBORNE FB8179

Dictated Rpt: Final 06/13/2006 00:00

Thoracic Surgery Clinic Note

FB8179

HOGGE, CLAIBORNE
6/13/2006
DOB: 6/24/1941 Age: 64
Thoracic Surgery Clinic Note
David H Harpole, MD
Duke Case Number 553267

DUKE UNIVERSITY MEDICAL CENTER
Division of Thoracic Surgery

DIAGNOSIS: Mesothelioma.

PROCEDURE: 05/24/06 Left extra pleural pneumonectomy.

PATHOLOGY: T2N0 epithelial variant mesothelioma.

CURRENT STATUS: Mr. Hogge returns for his first postoperative visit. He is doing well with the exception of a significant weight loss. He is down approximately 5 kg from his postoperative weight. He states that he has not had much appetite and has been unable to take supplements because it worsens his diabetes. His sugars have been running extremely low prior to bedtime and very high in the morning as he only takes half of the night time dose most of the time. Generally, his bedtime glucose has been between 40 and 50 at which time he takes half of his dose of the evening nph as well as having a snack and this is followed by high sugars up to the 300s in the morning. His pain is well-controlled and he is starting to wean off of his Oxycodone and is getting back to his normal activity level.

PHYSICAL EXAMINATION: Weight 64.7 kg down 5 kg. Temp 37.1. Heart rate 100. BP 138/72. 02 saturation is 99% on room air. He has no palpable supraclavicular or cervical adenopathy. Chest is clear to auscultation on the right. Heart is regular rate and rhythm. His incision is well-healed and staples are removed in the clinic today.

IMAGING STUDIES: Chest x-ray shows no evidence of infiltrate effusion or pneumothorax on the right, appropriate filling of the post pneumonectomy space on the left.

ASSESSMENT/PLAN: Mr. Hogge is recovering well from his extra pleural pneumonectomy. His current issues primarily center around nutrition. He was encouraged to increase his po intake and given the alternative of Glucerna shakes which should not affect his glucose management as much, he will contact Jonathan from Diabetes Management Service to adjust his insulin dosing, however, until he is able to do that, he was instructed to take half of his recommended dose of insulin at dinnertime which should increase his bedtime glucose level and allow him to take his full night time dose. His pathology was reviewed with him and his wife, and he is scheduled to return to the clinic in six weeks with a repeat chest x-ray at that time, and he will also be seen as a new patient by Dr. Crawford and Dr. Marks for planning of adjuvant therapy. Issues concerning treatment and diagnosis were discussed. There

are no barriers to communication, and the explanation was well received by the patient who then verbalized understanding. There was no change in allergies.

SHARI L MEYERSON, MD

David H. Harpole, MD
Division of Cardiovascular and Thoracic Surgery
ELECTRONICALLY SIGNED ON
June 20, 2006 AT 3:12:58 PM

SLM/jag
Dictated on: 6/15/2006
Transcribed on: 6/16/2006

Patient HOGGE, CLAIBORNE FB8179

Dictated Rpt Final 07/25/2006 00:00

Consultation

MRN: FB8179

HOGGE, CLAIBORNE
Date: 07/25/2006

DOB: 06/24/1941 Age: 65
Consultation
Attending: Lawrence B Marks, MD

RADIATION ONCOLOGY:

DIAGNOSIS:
Left pleural mesothelioma.

REQUESTING PHYSICIAN:
David Harold Harpole Jr., M.D.

HISTORY:
A 65-year-old gentleman with remote history of asbestos exposure who was noted to have an abnormality in his left lung on physical exam. Subsequent radiographs revealed left pleural fluid which initially was drained and apparently was benign. This reaccumulated soon thereafter. He underwent a VATS procedure in March which apparently included pleural biopsy. This revealed mesothelioma. Duke review of this also consistent with mesothelioma.

He was sent to see Dr. Harpole here at Duke. Scans revealed left pleural thickening and equivocal adenopathy. There was an equivocal abnormality in the right upper lung as well. Pulmonary function test were good, with FEV1 of 2.5 L, 83% predicted, DLCO 91%.

On 5/24/06, Dr. Harpole did an exploration and left extrapleural pneumonectomy. All gross tumor apparently was removed, as well as the diaphragm, and a portion of the pericardium. Multiple lymph nodes removed as well. Pathology report notes all the nodes to be negative. The prior port site was negative, as was a portion of rib. Within the pneumonectomy specimen, there was gross pleural thickening involving the visceral and parietal pleura, measuring about 1 cm in greatest dimension. The gross abnormality extended into the fissure. There was some thickness of the diaphragm, though there was no frank involvement of the diaphragm or pericardium. Microscopically, this was epithelial variant mesothelioma with confluent involvement of the visceral pleura with invasion into the lung. Margins were negative, no vascular invasion. Status of the diaphragm and pericardium is not committed upon. There were multiple lymph nodes in the hilar region of the lung specimen also which were free of tumor. This was staged pathologically as T2 N0.

Postoperatively, the patient has done reasonably well. He has fair amount of postoperative pain and has had a fair amount of weight loss as well and some weakness. He feels like he is slowly regaining his strength. He is able to walk up 1-2 flights of stairs presently without difficulty. We are asked to see him now for additional evaluation.

PAST MEDICAL HISTORY:

No prior cancers. No therapeutic radiation. He has had radiation exposure occupationally many years ago. He did work as a pipe fitter from 1959-1974, and apparently had asbestos exposure at that time. He has also had hemorrhoids, tonsils, and tendon surgery. He is insulin dependent diabetic.

CURRENT MEDICATIONS:
1. Insulin. 2. Protonix. 3. Lipitor. 4. Metamucil. 5. Dulcolax. 6. Zydone.

ALLERGIES:
Percocet apparently gave him hives and rash at one point.

SOCIAL HISTORY:
He did smoke 1-1/2 packs of tobacco per day for many years, quitting earlier this year. Social alcohol use. He is seen today with his wife, and they live in the Virginia area. They assist in caring for their grown son. The patient is a retired real estate broker.

REVIEW OF SYSTEMS:
Multiple findings since his surgery. Occasional cough and some shortness of breath. Some postoperative discomfort. Please see patient information sheet for more complete listing.

FAMILY HISTORY:
Mother with lymphosarcoma, live at age 88, and father died with colon cancer.

PHYSICAL EXAMINATION:
Well-developed adult male in no acute distress. BP 146/79, HR 96, weight 135.7 pounds, estimated KF is 80%. There is no adenopathy of the neck, supraclavicular region. No spine tenderness. No flank tenderness. Good breath sounds on the right, and transmitted sounds on the left. Regular cardiac rhythm. Abdomen: Soft, nontender without masses. The scars on the left chest are without nodularity, and appear to be healing well. No evidence of gross recurrence of tumor. Neurologic: Grossly intact.

STUDIES:
I have reviewed his preoperative CT scan, as well as the reports. There is clear thickening of the pleura on the left, extending into the fissures towards the hilar area. The nodes are equivocally enlarged in the mediastinum, not impressive. Very subtle abnormalities on the right side. The left pleural thickening is mostly posteriorly and in the central lung. Postop plain films reveal fluid accumulation in the left lung.

IMPRESSION AND PLAN:
Epithelial mesothelioma, status post total resection. Radiation to the tumor bed in the left hemi-chest is recommended to reduce the risk of local/regional recurrence. The patient would like to proceed with treatment, but is not sure whether he wants to do it here or elsewhere. He will think about this and let us know. Further, I would like to wait a few weeks before starting to try to regain some more of his strength, which seemed reasonable as well. I have discussed in depth with him the acute and late potential side effects of radiation. With the late side effects, we discussed injury to the kidney, stomach, esophagus, heart, lung, and esophagus. I believe that we can minimize the risk of injury with careful radiation planning, and the use of intensity modulated radiation techniques.

If the patient opts for treatment here at Duke, will need to arrange the following: 1. CT planning and cradle for IMRT, with bolus placed pre-CT. 2. PFTs. 3. Renal scan to be sure the right kidney functions well. 4. Laboratories to assess BUN and creatinine. 5. Consider heart study. 6. Pulmonary function tests. 7. Caring house referral.

The situation has been reviewed with Dr. Harpole who concurs with this plan.

ADDENDUM:
I also discussed with the patient the potential use of systemic chemotherapy, and he is apparently considering this as well. Given the patterns of failure for mesothelioma I believe that the radiation-component of therapy should perhaps be delivered prior to chemotherapy.

LAWRENCE B MARKS, MD
Department of Radiation Oncology
ELECTRONICALLY SIGNED ON
July 28, 2006 AT 12:02:14 PM

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DT: 07/26/2006
MEDQ/JOB: 586405/239989934

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Patient: HOGGE, CLAIBORNE FB8179

Dictated Rpt: Final 09/24/2006 00:00

TOP New Patient Evaluation

FB8179

HOGGE, CLAIBORNE
9/24/2006
DOB: 5/24/1941 Age: 65
TOP New Patient Evaluation
Jeffrey Crawford, MD
Duke Case Number 252972

PATIENT PROFILE: Mr. Hogge is a 65 year old gentleman referred to us from Dr. David Harpole at Duke University Medical Center for evaluation for adjuvent therapy for a left epithelial variant mesothelioma.

PROBLEM LIST:

1. Malignant mesothelioma
   a. On 2/28/06 patient developed shortness of breath and some pleuritic chest pain and presented to his primary care doctor in Virginia a chest x-ray
   b. Chest x-ray 03/06 showed some pleural thickening and left pleural effusion thoracentesis was performed; however did not reveal any malignant cytology.
   c. VATS performed 03/31/06 at outside hospital with biopsy showed malignant mesothelioma, also at this time pleurodesis was performed.
   d. 05/16/06 patient referred to Dr. David Harpole for consideration of pneumonectomy given the patient's new diagnosis of malignant mesothelioma.
   e. 05/23/06 CT of the chest/abdomen/pelvis shows circumferential thickening of the left sided pleura concerning for mesothelioma with involvement of the pleura along the left hemidiaphragm. Also showed a focal nodular opacity 8 mm in diameter in the right apex.
   f. 04/24/06 left extrapleural pneumonectomy was performed by Dr. David Harpole.
   g. Pathology of the resected pneumonectomy tissued showed no evidence of malignancy in the old port sites or level six or level five lymph nodes. The visceral pleura pathology was consistent with an epithelial variant malignant mesothelioma. Also five hilar lymph nodes were negative for any evidence of malignancy.
2. Diabetes Mellitus
3. Hyperlipidemia
4. Gastroesophageal reflux disease
5. Depression/anxiety

ALLERGIES: No known drug allergies.

INSURANCE/PRESCRIPTION INSURANCE: Patient has Medicare Part D.

SMOKING/EXPOSURE HISTORY: Patient has exposure to asbestos from 1969 to 1974 when he worked in the Newport News Virginia shipyard. He previously smoked a half pack per day until several years ago.

HISTORY OF PRESENT ILLNESS: Mr. Hogge is a very pleasant 65 year old gentleman who presents for evaluation for adjuvant chemotherapy in the setting of resected malignant mesothelioma of the epithelial variant. On 02/28/06 he developed some shortness from pleuritic chest pain and was evaluated by his primary care doctor in Virginia. A chest x-ray was obtained which showed some left pleural thickening and left pleural effusion. Thoracentesis was then performed by his primary care physician and fluid was obtained. The results of which we do not have currently; however this was apparently negative for any cytologic evidence of malignancy. At an outside hospital a VATS procedure was performed on 03/31/06 with biopsy showing malignant mesothelioma and pleurodesis was performed at this time. Patient was then referred to Dr. Harpole at Duke University Medical Center on 05/16/06 and CT scan was obtained which showed pleural thickening and a 1 cm

apical pleural nodule in the left pleura without evidence of enlarging lymph nodes or metastatic disease in the abdomen or pelvis. He then underwent an extrapleural pneumonectomy on 05/24/06 and the diagnosis of malignant mesothelioma was confirmed. Notably, lymph nodes at level 4 and 7 were negative for any metastatic disease and patient had negative margins and no vascular invasion on pathology.

Patient states he recovered well from his surgery and has been exercising and walking up to several miles per day; although more recently he has been involved in deposition for a class-action case for mesothelioma sufferers and is not been exercising as much as he was. He has had some weight loss after his surgery. He states he's had about 15 pounds in the past month or so. He has been attempting to increase his intake of food and supplements however he is very worried about his diabetes control and states his bowels become very irritated with any carbohydrate supplement. He is also had bouts of anxiety and sadness and has been taking Zydone which was prescribed for his post op pain, apparently for relaxation with his anxiety on a prn basis as well. Otherwise physically he states he has good energy level and has been playing golf on a regular basis as well as exercising. His only complaint today is the weight loss and the difficulty controlling his diabetes since his surgery.

PAST MEDICAL HISTORY:
1. Malignant mesothelioma
2. Diabetes
3. Hypercholesterolemia
4. Gastrointestinal reflux disease
5. Depression/anxiety
6. Constipation

PAST SURGICAL HISTORY:
None

FAMILY HISTORY: Mother has been treated for lymphosarcoma and still alive at age 88. Father died of colon cancer.

SOCIAL HISTORY: Patient has a 60 pack year smoking history, quite in May 2006. He is a retired banker and was involved in real estate. He is married and lives with his wife in Gloucester Virginia.

REVIEW OF SYSTEMS:
Constitutional: No fever, chills, night sweats. Patient has some loss of appetite and 15 pound weight loss, no change in sleep pattern.
Skin: No itching, rash, bruising or sores.
HEENT: No vertigo, sinus drainage, nose bleeds. No mouth, tongue or throat soreness. No mouth sores or ulcerations. No hoarseness or voice change. No facial pain or swelling.
Neck: No pain, swelling or stiffness.
Lymph Nodes: No enlarged or painful glands in neck, axilla or groin.
Cardiovascular: No chest pain, palpitations, pressure or tightness. No diaphoresis, rapid or irregular heart rate
Respiratory: No dyspnea on exertion or hemoptysis.
Gastrointestinal: The patient complains of some constipation, otherwise has no nausea, vomiting or diarrhea. No dysphagia, heartburn, reflux, bloating or belching. No hemorrhoids, black tarry stools, blood in stools or coffee ground emesis.
Genitourinary: No pain, frequency, hesitancy, nocturia, hematuria, incontinence, impotence.
Musculoskeletal: No bone or joint pain, swelling or stiffness. No muscle weakness. No back pain.
Extremities: No cyanosis, swelling edema or pain.
Neurologic: He's had some depression and anxiety otherwise no headaches, blurred vision, numbness or tingling, hearing loss, tinnitus, dizziness, balance problems, seizures, changes in speech or memory.

MEDICATIONS:
Insulin 18 units NPH qhs followed by 5 units regular qam; 13 units at lunch; 5 units at dinner.
Protonix 40 mg po q day
Lipitor 20 mg po qhs
Metamucil prn
Dulcolax prn
Zydone 1 tablet q6h for pain
Centrum vitamins po q day
Vitamin E 400 units po q day

PHYSICAL EXAMINATION: Patient Appearance: Reveals a very pleasant Caucasian man in no acute distress. BP 142/79, pulse 85, respiratory rate is 18 irregular. Temperature 36.1. Pain 0/10, fatigue 0/10.

Skin: Warm and dry. There are no rashes or lesions.

HEENT: PERRLA, EOMI, sclerae anicteric. He does have pterygia present on the edges of his corneas bilaterally. Oropharynx clear without lesions, exudates or thrush.

Neck: Supple without JVD or thyromegaly. No carotid bruits present.

Lymph Nodes: No cervical, supraclavicular, axillary or inguinal lymphadenopathy.

Lungs: Breath sounds are absent on the entire left lung fields. The left side is also hyper resident to percussion. On the right there is good air movement and normal breath sounds with no wheezes, crackles or rhonchi.

Thorax: Symmetric, full expansion bilaterally, no tenderness, no spinous process tenderness to palpation.

Cardiac: He has irregular rhythm. No murmur, rub or gallop. Normal S1 and S2.

Abdomen: Very thin, soft nontender and non distended. There is no hepatosplenomegaly or palpable abdominal masses present. Bowel sounds are normoactive.

Extremities: Pulses are 2+ in the radial also 2+ in the dorsalis Pedis and posterial tibialis arteries bilaterally. **Neurologic:** Alert and oriented X 4. CNII-XII grossly intact bilaterally. Strength 5/5 all extremities. Sensation to light touch and pinprick is grossly intact throughout bilaterally. Deep tendon reflexes are 2+ throughout. There is no ataxia on exam.

LABORATORY/RADIOLOGY DATA: Hemoglobin 11.7, hematocrit 38, WBC 6.7, platelet count 314, sodium 132, potassium 5.2, chloride 98, bicarb 27, BUN 13, creatinine .8, glucose is 288. PFTs show FEV1 of 1.61 liters that is 46% of predicted FEC is 2.58 liters which is 58% of predicted FEV1/FVC is 62%. Uric acid is 4.7, calcium is 8.9, phosphorus 3.5, total protein is 6.8, albumin 3.0, AST 21, ALT 0, alkaline phosphatase 111, bilirubin 0.5.

PAIN MANAGEMENT: 0/10.

ASSESSMENT AND PLAN: Mr. Hogee is a very pleasant 65 year old gentleman with recently resected malignant mesothelioma of the epithelial variant, after extrapleural pneumonectomy.

We had extensive discussion with the patient and his wife today at clinic regarding the likely course and possible therapy for his resectable mesothelioma. We noted to him that fully resectable mesothelioma is uncommon. Although case series are limited, we believe that radiation plus combination chemotherapy including Cisplatin and Alimta may have some benefit in decreasing recurrence and/or delaying time to relapse. Patient has already been seen by Dr. Marks in radiation oncology and is set to receive IMRT to the left lung area first. We will need to wait and see how he tolerates this before deciding on chemotherapy regimen. We did explain to him that he preferred chemotherapy would be Cisplatin plus Pemetrexed done after his XRT is completed.

The patient and his wife will likely stay here possibly in a local hotel while XRT is completed and at this point they have agreed to return to our clinic for further evaluation and likely studies to evaluate former current disease after XRT. Otherwise they agree to return to clinic in further discussions about the chemotherapeutic regimens that will be performed will be discussed. It was also noted to the patient that these regimens could also be given closer to his home as he does live in Virginia.

All the patients questions were answered to his satisfaction in the treatment plan was discussed in detail as per above. There were no barriers of understanding. Patient is to return to clinic at a later time once his XRT therapy is underway and he is doing well.

Issues concerning treatment and diagnosis were discussed. There were no barriers to understanding. The plan of treatment explanation was well received by the patient and family who then verbalized understanding.

Dr. Crawford and I together examined this patient and formulated the treatment plan.

Matt McKinney, M.D. For

Jeffrey Crawford, MD
Division of Hematology/Oncology
ELECTRONICALLY SIGNED ON
September 04, 2008 AT 11:45:21 AM

JC/cg
Dictated on: 8/22/2006
Transcribed on: 8/29/2006

Patient: HOGGE, CLAIBORNE FB8179

Dictated Rpt: Final 09/05/2006 00:00

Radiation Oncology Clinic Note

MRN: FB8179

HOGGE, CLAIBORNE
Date: 09/05/2006

DOB: Age:
Radiation Oncology Clinic Note
Attending: Lawrence B Marks, MD

RADIATION ONCOLOGY TREATMENT PLANNING:
The patient had treatment planning CT done recently. On this, we identified the left pleural space to be the clinical target volume. This was done with review of the preoperative imaging. Care was taken to include the visible pleural surfaces as well as subcutaneous tissues related to the chest scar.

Associated normal tissue such as the heart, right lung, kidneys, bowel, and esophagus were also identified. Doses/volume constraints were identified for anticipated MRT.

With a conventional AP/PA approach, it is not possible to deliver the desired dose to the inferior aspect of the tumor, without exceeding the cardiac and bowel tolerances. This is particularly challenging since the tumor wraps around the pericardial surface both anteriorly and posteriorly. Further, the target is quite close to the stomach and some bowel tissue in the left upper abdomen.

Therefore, an IMRT plan was generated. After several iterations of this, we settled on a plan which I believe adequately balances the target coverage and normal tissue concerns. Using 9 IMRT coplanar fields, we were able to deliver fairly good dose distribution to the target volume. We allowed a slightly lower dose to the portion of the target tissues that are immediately adjacent to the heart and bowel. We, therefore, defined a portion of the PTV where a lower dose was acceptable. In essence, we pushed the software to provide very rapid dose gradient in this vicinity. The trade off for this is a slightly higher heterogeneity within the PTV, and slightly cold doses in the PTV adjacent to the heart.

We identified the left ventricle as well, and tried to minimize the dose to this area.

With the current dose distribution, we could deliver about 45 Gy to the clinical target volume. The dose volume histograms to the liver, kidney, bowel, heart, and lung all appear reasonable. In particular, the lung doses appear good, with a medial lung dose of about 7 or 8 Gy. The superior aspect of the left kidney got significant dose but the right kidney and the lower left kidney are essentially spared.

The patient has agreed to participate in the Lance Armstrong Cardiac Toxicity Study. He appears to be a good candidate for this, as much of the heart is getting about 50% of the prescribed dose.

His PFTs done postoperatively appear reasonable with an FEV1 of 1.6 L and DLCO of 52% predicted.

Loose ends: Cardiac studies, renal scan.

LAWRENCE B MARKS, MD
Department of Radiation Oncology
ELECTRONICALLY SIGNED ON
September 08, 2006 AT 10:04:57 AM

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DT: 09/05/2006
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